

Resilience and depression: perspectives from primary care

Dowrick, Christopher; Kokanovic, Renata; Hegarty, Kelsey; Griffiths, Frances; Gunn, Jane

Postprint / Postprint

Zeitschriftenartikel / journal article

Zur Verfügung gestellt in Kooperation mit / provided in cooperation with:

www.peerproject.eu

Empfohlene Zitierung / Suggested Citation:

Dowrick, C., Kokanovic, R., Hegarty, K., Griffiths, F., & Gunn, J. (2008). Resilience and depression: perspectives from primary care. *Health*, 12(4), 439-452. <https://doi.org/10.1177/1363459308094419>

Nutzungsbedingungen:

Dieser Text wird unter dem "PEER Licence Agreement zur Verfügung" gestellt. Nähere Auskünfte zum PEER-Projekt finden Sie hier: <http://www.peerproject.eu> Gewährt wird ein nicht exklusives, nicht übertragbares, persönliches und beschränktes Recht auf Nutzung dieses Dokuments. Dieses Dokument ist ausschließlich für den persönlichen, nicht-kommerziellen Gebrauch bestimmt. Auf sämtlichen Kopien dieses Dokuments müssen alle Urheberrechtshinweise und sonstigen Hinweise auf gesetzlichen Schutz beibehalten werden. Sie dürfen dieses Dokument nicht in irgendeiner Weise abändern, noch dürfen Sie dieses Dokument für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, aufführen, vertreiben oder anderweitig nutzen.

Mit der Verwendung dieses Dokuments erkennen Sie die Nutzungsbedingungen an.

gesis
Leibniz-Institut
für Sozialwissenschaften

Terms of use:

This document is made available under the "PEER Licence Agreement". For more Information regarding the PEER-project see: <http://www.peerproject.eu> This document is solely intended for your personal, non-commercial use. All of the copies of this documents must retain all copyright information and other information regarding legal protection. You are not allowed to alter this document in any way, to copy it for public or commercial purposes, to exhibit the document in public, to perform, distribute or otherwise use the document in public.

By using this particular document, you accept the above-stated conditions of use.

Mitglied der

Leibniz-Gemeinschaft

Resilience and depression: perspectives from primary care

**Christopher Dowrick, Renata Kokanovic,
Kelsey Hegarty, Frances Griffiths and Jane Gunn**

*University of Liverpool, UK, University of Melbourne, Australia, University
of Melbourne, Australia, University of Warwick, UK & University of
Melbourne, Australia*

ABSTRACT Resilience refers to the capacity for successful adaptation or change in the face of adversity. This concept has rarely been applied to the study of distress and depression. We propose two key elements of resilience – *ordinary magic* and *personal medicine* – which enable people to survive and flourish despite current experience of emotional distress. We investigate the extent to which these elements are considered important by a sample of 100 people, drawn from a longitudinal study of the management of depression in primary care in Victoria, Australia. We also assess how respondents rate personal resilience in comparison with help received from professional sources. Our data are obtained from semi-structured telephone interviews, and analysed inductively through refinement of our theoretical framework. We find substantial evidence of resilience both in terms of ordinary magic – drawing on existing social support and affectional bonds; and in terms of personal medicine – building on personal strengths and expanding positive emotions. There is a strong preference for personal over professional approaches to dealing with mental health problems. We conclude that personal resilience is important in the minds of our respondents, and that these elements should be actively considered in future research involving people with experience of mental health problems.

KEYWORDS *distress; ordinary magic; personal medicine; primary care; resilience*

ADDRESS Christopher Dowrick, Division of Primary Care, University of Liverpool, Liverpool L69 3GB, UK. [Tel: +44 0151 794 5597; fax: +44 0151 794 5604; e-mail: cfd@liv.ac.uk]

Introduction

What is resilience?

Stuart Diver was trapped for 65 hours by tonnes of concrete, following a landslide at a ski resort. Hundreds of thousands of people pondered their own response in such extraordinary circumstances, as they watched the live telecast of his rescue (Diver, 1999). Joe Simpson found himself trapped in an ice cave high up in the Andes, with broken bones after a terrible fall, but somehow managed to struggle back to base camp (Simpson, 1988). In *Life of Pi* a young boy finds himself marooned on a lifeboat in the middle of the Indian Ocean, with only a Royal Bengal tiger for company: a voice inside him said 'I will not die, I refuse it. I will make it through this nightmare' (Martel, 2002: 147). Why don't these people just accept the logic of their situation, and simply give up all hope of survival? Human beings, it seems, have an amazing capacity to overcome adversity: a sense of resilience.

Resilience, according to the *Oxford English Dictionary*, is 'the ability to rebound or spring back, the power of something to resume its original shape or position after compression or bending' (OED online). In philosophical terms, it can be understood within Spinoza's concept of *conatus*: a word variously translated as striving, endeavour, tendency and effort, and also with meanings related to power, will, appetite and desire. Spinoza sees *conatus* as the essential attribute of all things, and in particular of human beings. It is our striving towards self-maintenance. 'Each thing, in so far as it is in itself, endeavours to persevere in its being' (Spinoza, 2000: III, 6).

For health researchers, resilience is an interactive concept which refers to the capacity for successful adaptation in adversity, the ability to bounce back after encountering difficulties, negative events or hard times (Rutter, 2006). It includes a sense of self-esteem or self-confidence, patience and the ability to adapt to changing circumstances, humour in the face of difficulties and a belief that problems can be solved (Connor and Davidson, 2003).

In *Out of the woods*, Stuart Hauser and his colleagues (2006) explore the concept of resilience through the narratives of teenagers who have recovered from serious psychiatric illness, and gone on to lead fulfilling lives. Three central themes emerge. First, a sense of personal agency, the belief that we can influence our environment: we try things and learn from them; even if they do not go well, we are capable of making purposeful change. Second, an inner focus, the ability to handle our own thoughts and feelings, coupled with an interest in how our thoughts and minds work. Third is the capacity to form caring relationships. These narratives encourage us to focus on identifying the seeds of resilience – even when they are shrouded in adolescent rebellion – and nurture them as the first signs of strength.

Resilience also has a more profound meaning. It is not just that we can survive: we can also expand our psychological resources in the face of adversity (Fredrickson, 2003). When things go wrong we have the capacity to flourish, and come out stronger than we were before. If we take the

example of women living in abusive relationships, recovery is not seen as returning to 'normal' but rather constructing a self (often an activist self) built on the experience of having survived such a relationship (Profitt, 2000; Harvey et al., 2002; Taylor, 2004). The sense of self can be in either a reflective, internal sense or an external social context. Reclaiming the self – often through relating with other women who have shared experiences – may be a stage where women move from surviving to thriving.

Resilience and depression

The many and various factors thought to predispose people to become depressed are frequently described. They include adverse events in childhood, certain personality types, the presence of co-existing, personal or family history of mental health problems and longstanding physical illnesses. Gender (Astbury and Cabral, 2000), social role and environmental factors all play their part, and there may also be a genetic element (Caspi et al., 2003). The things that general practitioners and other health professionals are supposed to do to help people diagnosed with depression – including prescribing antidepressant medications and providing access to psychological therapies – have also been voluminously researched and energetically promoted (NCCMH, 2004).

There has been much less emphasis on understanding the factors which affect our resilience to distress, on describing what enables us to survive and bounce back (and even flourish) despite adversity.

Despite the burgeoning interest in professional and pharmacological approaches to building resilience (Nemeroff and Vale, 2005; Richell et al., 2005), it is important to be aware of the limitations – and even the potentially negative impact – of such interventions. The Cambridge-Somerville Youth Study, for example, was launched by Cabot in 1937 to prove that 'skilled and directed friendship' could reduce delinquency in boys. However, this controlled experiment produced unexpected results, with boys in the intervention group having poorer outcomes, including being convicted of more crimes. Many explanations have been offered for this paradoxical finding, but the ideas that the intervention led to learned helplessness or reduced the boys' resilience must be considered as strong possibilities (Oakley, 2000). Similarly, interventions for post-traumatic stress disorder may cause more harm than good. Single session individual debriefing neither reduces psychological distress nor prevents the onset of post-traumatic stress disorder and may increase the risk of post-traumatic stress disorder in the long term (Rose et al., 2002). Acknowledging the presence and importance of personal resilience, therefore, requires us to recognize and voice the limitations of professional intervention.

Our concerns are with the *personal* elements of resilience. What can we ourselves do to maintain a healthy and fulfilling life, if we are born with the short variant of the serotonin transporter gene, subjected to physical or sexual abuse as a child or adult, forced to migrate from our home country,

live in damp and overcrowded accommodation, become a lone parent or develop diabetes?

We suggest an answer with two key elements: ordinary magic, and personal medicine.

Ordinary magic

We take the view that resilience is not an extraordinary process. For most of us it derives from ordinary things, from family love and close friendships, and from positive experiences in the worlds of education and work (Masten, 2001). Caring and loving parents, friendships developed as children and teenagers and close relationships as adults (whether at home, at work or in our social lives) all help us to develop resilience against adversity. Resilience is strongly associated with social support (O'Reilly, 1988), the availability of people who perform helpful functions including emotional concern, practical aid and information (Harris et al., 1999). Social support acts as a buffer, providing us with protection between adverse life events and the likelihood of consequent distress (Brown et al., 1986; Alvarez and Hunt, 2005). It can also derive from our social role. Black Caribbean women in Britain, for example, tend to normalize distress and assume a self-concept that stresses the importance of being a 'Strong-Black-Woman': this maintains psychological well-being, and reinforces notions of empowerment (Edge and Rogers, 2005).

Personal medicine

It is not just a question of whether or not we are born with resilience, or whether we develop it as a result of what other people do for us, or our defined social role. We can also take steps to expand our own, inner resources. We can develop our own personal medicine, a range of activities designed to give our lives greater meaning and purpose (Deegan, 2005).

If we are not fortunate enough to have experienced strong affectional bonds as children, or to have ready-made supportive social networks, we can make up for earlier lacks or losses. If our early childhood experiences are adverse, much of the resulting damage can be overcome through nurturing relationships in adolescence and adult life (Rutter, 1987; Wright et al., 2005). Children of depressed people can consciously and successfully make their own intimate relationships different from those of their parents (Peisah et al., 2004).

In *Beyond depression*, Christopher Dowrick (2004) proposes an understanding of the self that enhances our personal resilience. It involves an awareness of ourselves as curious, imaginative persons with an innate desire to survive; persons with a sense of geographical and historical place, actively involved within a complex set of roles, supports and obligations; persons with the capacity to promote and shape our engagement with the world and, in conversation with others, to enhance ability to lead purposive, meaningful

lives. Our social and conversational networks, our webs of interlocution, are important sources of support in time of trouble and enable us to build up reserves of strength in the future. Resilience emerges from our exercise of ingenuity and imagination, from learning the art of living intelligently with misunderstanding, coping with the increasing complexity of other individuals and the multiplicity of their moods and engaging in activities beyond ourselves. It emerges from our practices and our conversations, in which we feel understood and appreciated, and discover new ideas to think about, new directions for taking action, new meanings.

Martin Seligman and colleagues have produced a systematic classification and measurement of what they consider to be universal strengths and virtues. In the process they have identified five key personal strengths that are most strongly associated with life satisfaction: hope, zest, curiosity, gratitude and love (Peterson and Seligman, 2004). They show how we can find significant benefits through identifying our own 'signature strengths', and deliberately using them in new ways (Seligman et al., 2005). Seligman (2002) goes on to distinguish three possibilities for positive emotional direction: the pleasant life, concerned with the gratification of our immediate desires and needs; the good life, which involves us in gratifying engagement outside ourselves, whether in work, love or play; and the meaningful life, in which we place ourselves in the service of something larger than ourselves.

Barbara Fredrickson (2001) encourages us to build on our positive emotions, because our repertoire of thoughts and actions expands as we do so. Joy sparks the urge to play, interest sparks the urge to explore, contentment sparks the urge to savour and integrate, and love sparks a recurring cycle of each of these urges within safe, close relationships. Broadening our minds in these ways, whether through play, exploration, savouring or integrating, promotes discovery of new and creative actions, ideas and social networks which in turn build up our personal resources and provide lasting reserves which can be drawn on if life gets difficult again.

Our objectives

In this article, we explore the views of people with experience of depression, with regard to their resilience in the face of adversity.

The principal question we consider is: which elements of personal resilience do people with experience of depression consider important in enabling them to survive, recover or flourish? Specifically, we investigate the extent of personal resilience expressed by respondents, in terms of how they draw on the elements of 'ordinary magic', and how they seek to generate their own 'personal medicine'. We also assess how they rate the importance of personal resilience, in comparison with help received from professional sources.

Methods

Sampling

The data presented here come from a large longitudinal study of the management of depression in primary care, from the state of Victoria in Australia (Gunn, 2006). Participants were recruited via a sample of 30 randomly selected general practitioners (GPs). From each GP, 600 patients who had seen their GP for any reason over the previous 12 months were randomly selected, then screened for depression via a postal survey, using the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977). People identified as experiencing symptoms of depression (i.e. those scoring 16 or more on the CES-D) were invited into the longitudinal study, of whom just under half agreed to do so. About half of those interviewed fulfilled criteria for recent major depressive disorder (World Health Organization, 1997).

Procedure

Study participants completed computer assisted telephone interviews (CATI), conducted by trained interviewers, between January and May 2006. A semi-structured guide was used, which involved discussion of participants' experiences of depression, their views on the causes of distress, ways to manage and address depression and distress, forms of social support and health service use. Most interviews were one hour long. Responses were typed verbatim into a database designed for that purpose. Textual data from the first 100 CATI interviews were extracted for the analysis. Of these 100 people, 62 were women, 63 came from rural areas, 48 were married (and 20 divorced), 23 lived alone, 50 were in paid employment (and 12 were unable to work due to sickness or disability) and the median age was 50 years. All interviews were conducted with people speaking English.

In this article we focus on the responses to three questions: 'When you first realized you had an issue with depression, stress and worries, what was the first thing you decided to do about it?' 'Apart from what you have just mentioned, is there anything else that you have tried for depression, stress and worries?' 'Of everything you have done/ tried, what was the most helpful?'

Analysis

The objective of our data analysis was to test our proposed model of personal resilience by eliciting representations and concepts of resilience through identification of provisional primary level constructs (Hayes, 1994) drawn from the data, and assessing them against our theoretical framework. Following transcription, the results of independent analysis conducted by RK and CD were compared and discrepancies discussed. Through the discussion, operationalized definitions were developed and refined (Stern and Kirmayer, 2004). Categories and subcategories were

further developed, assessed against our theoretical framework and refined. We sought evidence to oppose or disconfirm our framework. We refer to all participants by pseudonym and indicate age.

Ethics

Ethical approval for this study was granted by the University of Melbourne's Human Research Ethics Committee.

Findings

Drawing on ordinary magic

About a third of respondents reported benefit from their existing affectional bonds and social networks, or from their social roles.

Many people specifically mentioned support from one or more members of their family, for example 'I think talking to my wife would've been the most beneficial of them all' (George, 47); 'Umm ... to be honest probably my husband and my family' (Maria, 48).

Many also made explicit reference to helpful friends, for example: 'being able to talk about it with a group of close friends' (Alice, 27); 'having friends there when I need them most' (Sara, 35).

A few people reported help from colleagues in work, including one sympathetic boss. The emphasis in this account is on support from others in adversity, rather than personal agency:

I just gradually went down hill, I lost a tremendous amount of weight, my work performance was down, and my boss noticed and he knew my wife had left me and he asked me if I'd thought about suicide and made me promise that I wouldn't do anything in the next few days and arranged for me to see his psychiatrist – his father had shot himself in the head, and he recognized what I was going through and he knew that I had separated from my wife. I was very lucky to have him there at the time. (Mark, 49)

In contrast, one woman found substantial benefit from her social role as a nurse. She did not simply find work as a means of social support, but also used her role to help her to get through a period of severe adversity, with a combination of personal agency and inner focus.

I started uni, I was a Division 2 nurse, and I'm doing my Division 1, but I had planned to do that before my husband died ... but I think in my own mind I knew I needed to continue that to get through what I was feeling. I needed a focus, I was aware of that black pit, that the easiest way for me would've been to slip into that black pit, but I knew I couldn't do that. I think for my own sanity, I knew that I couldn't do that. So, to have that focus, and it has worked. (Kate, 46)

Generating personal medicine

Respondents indicated three main aspects of personal medicine, where they were actively taking steps to improve their own situation: building on

personal strengths, expanding positive emotions and extending affectional bonds and social networks.

Personal strengths About one-third of respondents indicated an awareness of the importance of their own personal virtues and strengths, and most who did so believed that they had the capacity to use these to get better. Many of these people said they were able to ‘deal with’ their depression, stress or worries on their own.

For some this involved a change in attitudes or cognitions:

Accepting it and dealing with it. Realizing it. (Sally, 21)

Really just get my head together and put myself on a straight line sort of, realize that what you’ve got is a problem and you’re gonna have to live with it. You see other people that are a lot worse and you think I’m not so bad after all. (Adam, 53)

Let yourself feel what you have to, so if you need to cry or shut yourself off or want to be on your own, I do it, it doesn’t mean I’m suffering bad depression, it’s just an issue I’m going through, it’s an emotion. Like if you need to sleep 12 hours, sleep it, don’t worry about it, you know, not to be too hard on yourself. Doing what Kelly wants to do, I’ll get over it. I’ve learnt to ease off and be less rigid. If I don’t want to do something, I won’t do it. It’s been 12 years, and this is finally ... instead of worrying about others, you’re worrying about yourself. (Kelly, 37)

While for others it also involved taking direct action:

Tried to straighten up, I know that – my kids were involved and I had to make sure that they didn’t get lost in the court f*****g system somewhere, you know what I mean? ... you know, I was doing a lot of drugs and drinking, and just wanted to straighten myself up. (Steven, 56)

Expanding positive emotions About a third of respondents reported doing things that were explicit extensions of or changes from their previous modes of living, and which actively expanded their positive emotions.

The most helpful would be the change of diet, fresh air and exercise. (Christine, 32)

I used to lay on the couch and listen to Mozart. I am a big fan of classical music. It really calms me down. (John, 47)

I’ve played sport for all my life, so that’s always, that’s helped. I don’t do sport as a specific thing to deal with depression, stress or worries. I think that thing that’s been solely to deal with it has been the meditation or breathing. Also writing a journal. (Sophie, 42)

Well obviously I come from the bush so I just go out and chop away at a heap of wood! Seriously. (Andrew, 70)

...just go and ride my motorbike. That’s the best thing for you. (Peter, 42)

Extending bonds and networks Several respondents described how new affectional bonds and social networks were helping them to move forward:

I've just got a new grandson and that gives me a positive outlook for the future. I'm looking forward to showing him around the farm ... I think I'm travelling pretty well at the moment. (Brad, 57)

I've got a new puppy dog. (Val, 64)

There was little evidence that respondents were building personal medicine based on their curiosity and imagination, or increasing (as opposed to sustaining) their engagement in social, economic or political spheres, or deliberately seeking to create a more meaningful life for themselves. Although several respondents spoke about their 'faith in God', this was usually described in terms of the existing support networks available to them.

Personal resilience or professional help?

First actions When asked about 'the first thing you decided to do' about depression, stress or worries, the majority of people gave positive responses. They were much more likely to look first to personal or informal social resources, rather than seeking professional help. Among those whose first step was to seek professional help, most said they consulted their GP.

Most helpful actions When asked 'what was the most helpful' thing for depression, stress or worries, the great majority of people gave clear responses. Again, there was a clear balance of opinion in favour of the benefits of personal and informal social resources, rather than professional help.

Almost half of all respondents said that personal and informal resources were most helpful to them. They cited lifestyle changes, support from family or friends and self-help (including changes in working patterns) to be the most important element. Among the minority who thought professional interventions were the most helpful, the most commonly cited professionals were counsellors and GPs. Medication was also seen as a key independent element in recovery. A few people gave equal weight to medication and counselling, or to medication and personal or informal resources, while some expressed ambivalence or antipathy to antidepressant medication.

Discussion

Summary of findings

There was substantial evidence of resilience among these 100 respondents, both in terms of ordinary magic – drawing on existing social support and affectional bonds; and in terms of personal medicine – building on personal strengths and expanding positive emotions. There was less evidence that respondents were active in building affectional bonds and support.

There was little or no evidence that respondents sought to enhance their resilience by expanding their curiosity and imagination, increasing their social engagement or creating a more meaningful life. There was a strong preference for personal rather than professional approaches to dealing with their mental health problems.

Relationship to existing literature

This is the first study to seek direct evidence of personal resilience from a primary care sample of people experiencing depressive symptoms. Our findings support the models of personal resilience proposed by Seligman (personal virtues and strengths) and Fredrickson (expanding positive emotions). They give partial support to the model proposed by Dowrick: there is strong evidence here for the importance of our webs of interlocution, and social engagement. However, our respondents said little about actively building up their inner strengths, or about the generation of new meanings. Our findings also resonate with themes identified by Hauser and colleagues: generating personal medicine is based on the belief that we can influence our environment, and on the practice of trying things and learning from them; while an awareness of personal strengths indicates the ability for inner focus.

Our respondents were likely to use personal or social resources in the first instance to manage their mental health problems. The issue of seeing the problem ‘as their own issue’ parallels abused women’s experience (Hegarty and Taft, 2001): if a person looks at depression or intimate partner violence as being their own problem, then they are inclined to turn first to family, friends and personal resources. Even though this was a sample recruited through primary care, our respondents tended to view personal and social resources as more beneficial than professional help, perhaps an indication that concerns about the stigma associated with professional interventions retain potency (Givens et al., 2007).

Study limitations

Our respondents were drawn from a cohort of people who had been in recent contact with a general practitioner, and had depressive symptoms at the time of screening: that is, people who can be assumed to view primary care as a useful means of help. Therefore their views would tend to over-estimate importance of primary care professional help, in comparison with a sample drawn from the community at large.

This is a secondary analysis, as the questions posed in this article were not the primary focus of the original research. The specific questions used in this analysis were posed within a wider context of understanding the role of primary care in management of depression.

Our theoretical objective was to test a new model of personal resilience. We therefore sought evidence to confirm and oppose this model, and found

both. We did not seek to create or test alternative explanatory frameworks.

Although the interview schedule was semi-structured, our researchers were working within tight time constraints and there was limited opportunity to probe for more extensive answers. It is likely, therefore, that these interviews were limited in their ability to generate information on more subtle aspects of personal resilience, for example the development of curiosity and imagination, or strategies to enhance meaning-making.

Conclusions

Personal resilience is alive and well, and appears to be important in the minds of our respondents. The similarity in themes compared with published studies provides evidence that we are building an understanding of resilience among people with experience of depressive symptoms in primary care.

We will use these findings to build an analytic framework which will enable us: (a) to undertake a comprehensive analysis of patterns of personal resilience among the whole of the study baseline sample; and (b) to generate a set of predictions about how personal resilience may affect outcome, which we will test empirically against the longitudinal follow-up findings from this study cohort. For example, we will examine the extent to which participants' views about the causes of depression are related to their views about remedies and their sense of personal agency (Karasz, 2005); and the extent to which the contrasting ways in which our respondents draw upon ordinary magic (e.g. social support versus inner focus) are associated with differences in outcome.

We will then use this greater understanding of how personal resilience can help people to overcome depressive symptoms to inform future training programmes with primary care practitioners. These will focus on enabling practitioners to identify sources and types of resilience, and to assist their patients to build upon them, rather than take them away.

References

- Alvarez, J. and Hunt, M. (2005). Risk and resilience in canine search and rescue handlers after 9/11. *Journal of Trauma and Stress*, 18(5), 497–505.
- Astbury, J. and Cabral, M. (2000). *Women's mental health: An evidence based review*. Geneva: World Health Organization.
- Brown, G., Andrews, B., Harris, T., Adler, Z. and Bridge, L. (1986). Social support, self-esteem and depression. *Psychological Medicine*, 16(4), 813–31.
- Caspi, A., Sugden, K., Moffitt, T.E. et al. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science*, 301(5631), 386–9.
- Connor, K.M. and Davidson, J.R. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety*, 18(2), 76–82.

- Deegan, P.E. (2005). The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities. *Scandinavian Journal of Public Health Supplement*, 66, 29–35.
- Diver, S. (1999). *Survival*. London: Pan Macmillan.
- Dowrick, C. (2004). *Beyond depression*. Oxford: Oxford University Press.
- Edge, D. and Rogers, A. (2005). Dealing with it: Black Caribbean women's response to adversity and psychological distress associated with pregnancy, childbirth, and early motherhood. *Social Science and Medicine*, 61(1), 15–25.
- Fredrickson, B.L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist*, 56(3), 218–26.
- Fredrickson, B.L. (2003). The value of positive emotions. *American Scientist*, 91, 330–5.
- Givens, J.L., Katz, I.R., Bellamy, S. and Holmes, W.C. (2007). Stigma and the acceptability of depression treatments among African Americans and whites. *Journal of General Internal Medicine*, 22(9), 1292–7.
- Gunn, J. (2006). Depression as a chronic and disabling experience. The DIAMOND study: A longitudinal naturalistic study of depression in primary care in Victoria, Australia. *Journal of Affective Disorders*, 91, S21–S22.
- Harris, T., Brown, G.W. and Robinson, R. (1999). Befriending as an intervention for chronic depression among women in an inner city. *British Journal of Psychiatry*, 174(March), 219–24.
- Harvey, M.R., Mishler, E.G., Koenen, K. and Harney, P.A. (2002). In the aftermath of sexual abuse: Making and remaking meaning in narratives of trauma and recovery. *Narrative Inquiry*, 10, 291–311.
- Hauser, S.T., Allen, J.P. and Golden, E. (2006). *Out of the woods*. Cambridge, MA: Harvard University Press.
- Hayes, B.E. (1994). How to measure empowerment. *Qualitative Progress*, 1, 41–6.
- Hegarty, K. and Taft, A. (2001). Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. *Australian and New Zealand Journal of Public Health*, 25(5), 433–8.
- Karasz, A. (2005). Cultural differences in conceptual models of depression. *Social Science and Medicine*, 60(7), 1625–35.
- Martel, Y. (2002). *Life of Pi*. Edinburgh: Canongate.
- Masten, A.S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56(3), 227–38.
- National Collaborating Centre for Mental Health (NCCMH). (2004). *Clinical Guideline 23. Management of depression in primary and secondary care*. London: National Institute for Clinical Excellence.
- Nemeroff, C.B. and Vale, W.W. (2005). The neurobiology of depression: Inroads to treatment and new drug discovery. *Journal of Clinical Psychiatry*, 66(Suppl. 7), 5–13.
- Oakely, A. (2000). *Experiments in knowing*. Cambridge, UK: Polity Press, pp. 177–80.
- O'Reilly, P. (1988). Methodological issues in social support and social network research. *Social Science and Medicine*, 26(8), 863–73.
- Oxford English Dictionary online. <http://dictionary.oed.com/>
- Peisah, C., Brodaty, H., Luscombe, G. and Anstey, K.J. (2004). Children of a cohort of depressed patients 25 years later: Psychopathology and relationships.

- Journal of Affective Disorders*, 82(3), 385–94.
- Peterson, C. and Seligman, M. (2004). *Character strengths and virtues: A handbook and classification*. Washington, DC: American Psychological Association.
- Profitt, N.J. (2000). Survivors of woman abuse: Compassionate fires inspire collective action for social change. *Journal of Progressive Human Services*, 11, 77–102.
- Radloff, L. (1977). The CES-D scale: A self-report major depressive disorder scale for research in the general population. *Applied Psychological Measurement*, 1, 305–401.
- Richell, R.A., Deakin, J.F. and Anderson, I.M. (2005). Effect of acute tryptophan depletion on the response to controllable and uncontrollable noise stress. *Biological Psychiatry*, 57(3), 295–300.
- Rose, S., Bisson, J., Churchill, R. and Wessely, S. (2002). *Psychological debriefing for preventing post traumatic stress disorder (PTSD)*. Cochrane Database Systematic Review: CD000560.
- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57(3), 316–31.
- Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of the New York Academy of Sciences*, 1094, 1–12.
- Seligman, M. (2002). *Authentic happiness*. New York: Free Press.
- Seligman, M., Steen, T., Park, N. and Peterson, C. (2005). Positive psychology: Empirical validation of interventions. *American Psychologist*, 60(5), 410–21.
- Simpson, J. (1988). *Touching the void*. London: Jonathan Cape.
- Spinoza, B. *Ethics*. (2000). Ed. and trans. G.H.R. Parkinson. Part III, proposition 6. Oxford: Oxford University Press.
- Stern, L. and Kirmayer, L. (2004). Knowledge structures in illness narratives: Development and reliability of a coding scheme. *Transcultural Psychiatry*, 41(1), 130–42.
- Taylor, J.Y. (2004). Moving from surviving to thriving: African American women recovering from intimate male partner abuse. *Research and Theory of Nursing Practice*, 18(1), 35–50.
- World Health Organization. (1997). *Composite International Diagnostic Interview (CIDI-Auto)*, Version 2.1. Geneva: World Health Organization.
- Wright, M.O., Fopma-Loy, J. and Fischer, S. (2005). Multidimensional assessment of resilience in mothers who are child sexual abuse survivors. *Child Abuse and Neglect*, 29(10), 1173–93.

Author biographies

CHRISTOPHER DOWRICK is Professor of Primary Medical Care at the University of Liverpool, UK. His research portfolio focuses on mental health in primary care settings, with particular reference to depression and medically unexplained symptoms. He is interested in developing conceptual models and health care practices that recognize the strengths and abilities of people with experience of mental health problems, and minimize unnecessary dependence on medical interventions.

RENATA KOKANOVIC is medical sociologist, Senior Research Fellow at the University of Melbourne. Renata's research interests include experiences of health and illness and cultural differences in mental health, focusing on depression.

KELSEY HEGARTY is Associate Professor of General Practice at the University of Melbourne, Australia. Her research interest focuses on women's experience of intimate partner violence and depression in primary care settings, with particular reference to how social issues influence the emotional health of the community. She is interested in developing models of responding to sensitive issues such as domestic violence in the primary care setting.

FRANCES GRIFFITHS is Associate Clinical Professor at the Health Sciences Research Institute, University of Warwick. She leads a programme of research on complexity and health care. The programme aims to develop the evidence base for primary care research, informed by ideas of complexity sciences and drawing on diverse levels of analysis including the political, social, cultural, family, individual and biological.

JANE GUNN is Professor of Primary Care Research at the University of Melbourne, Australia. Her research interests focus on depression and related disorders and the way they are conceptualized, identified and managed in the primary care setting. She is interested in developing models of primary care that take full account of lay and practitioner experience with depression.